Town & Country
Compounding and Consultation

"Customized, Patient Specific, Compounded Medications"

ZRT Lab Tests - Reimbursement Form

Patient Name: _____ **Physician's Name:** _____

Address: _____ **Address:** _____

_____ _____

Date of Service: _____ **Diagnosis Code(S)/ICD-9:** _____

(Date of service is located on the test report) _____

(Place an "X" in the box next to each test that was performed and change quantity if required).

X	TEST	CPT Code	Quantity	Price
	Estriol (saliva)	82677	1	
	Estrone (saliva)	82679	1	
	Estradiol (Saliva)	82670	1	
	Progesterone (Saliva)	84144	1	
	Testosterone (Saliva)	84402	1	
	DHEA-S (Saliva)	82627	1	
	Cortisol (Saliva)	82530		
	Vitamin D, 25-OH, Total (Blood)	82306	1	
	Luteinizing Hormone (Blood)	83002	1	
	Follicle Stimulating Hormone (Blood)	83001	1	
	Sometomedin C (Blood)	84305	1	
	Estradiol, Total (Blood)	82670	1	
	Progesterone, Total (Blood)	84144	1	
	Testosterone, Total (Blood)	84403	1	
	DHEA-S (Blood)	82627	1	
	Cortisol (Blood)	82533	1	
	Sex Hormone Binding Globulin (Blood)	84270	1	
	Prostate Specific Antigen (Blood)	84153	1	
	Free Thyroxine (Blood)	84439	1	
	Free Triiodothyronine (Blood)	84481	1	
	Thyroid Stimulating Hormone (Blood)	84443	1	
	Thyroid Peroxidase Antibody (Blood)	86376	1	
	Insulin, Fasting (Blood)	83525	1	
	High Sensitivity C-Reactive Protein (Blood)	86141	1	
	Hemoglobin A1c (Blood)	83036	1	
	Triglycerides (Blood)	84478	1	

Test(s) Performed by: **ZRT Laboratory**
8605 SW Creekside Pl
Beaverton, OR 97008

CLIA# 38D 0960950
EIN/TAX ID # 93-1252924
Place of Service: 81
NPI# 1740356872

Complete your Insurance Company's claim form. Attach a copy of the receipt for the kit purchase along with the doctor's order of prescription. Mail all of the information listed in addition to this form to your insurance Company.

ZRT Saliva Profile 1: E2 (Estradiol); Pg Progesterone); T (Testosterone); DS (DHEA-S); + (1) C (Cortisol)

ZRT Saliva Profile 2: E2 (Estradiol); Pg Progesterone); T (Testosterone); DS (DHEA-S); + (2) C (Cortisol)

ZRT Saliva Profile 3: E2 (Estradiol); Pg Progesterone); T (Testosterone); DS (DHEA-S); + (3) C (Cortisol)

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I certify that the above services have been rendered and the fees submitted are those that have been charged to the indicated patient.

Provider Signature: _____

Date: _____ **License #: R118042**

106 Prospect Street, Ridgewood, NJ 07450 Ofc: 201-447-2020 Fax: 201-447-3253
www.tccompound.com tompellegrino@tccompound.com